PIP item 1B.2 Improve the quality of assessments
1B.2.1 Seek TA from Substance Abuse in Child Welfare NRC to develop a statewide substance abuse training component focusing on assessment and service provision for families dealing with substance abuse.

Kentucky IDTA
Current Status and Proposed Activities
September 9, 2011

Following is a checklist outlining the major activities Kentucky has accomplished during the IDTA and those that they plan for the coming year. Some specific major accomplishments have been:

- Completion of a virtual walk through of the three systems.
- Detailed discussion and agreement on collective collaborative values.
- A good start to the practice guide, with background, sections on: (a) screening and assessment, (b) drug testing and (c) confidentiality and information sharing in near final form.
- Piloting of the UNCOPE in DCBS, with the expectation of going system wide next year.
- Conducting Regional Forums for the purposes of sharing the approaches and products developed through the IDTA, obtaining stakeholder input, and stimulating regional interagency collaboration.
- Piloting merges of data to form the basis for future data sharing.
- Conducting a training inventory and beginning to establish priorities for a training plan.
- Inventoried current funding sources and the types of services supported as the basis for sustainability planning.
- Developed a draft MOU for continuation of the Kentucky Partnership after the IDTA ends.

As noted in the checklist, each of these activities have additional steps, which Kentucky plans to accomplish over the next nine months and following completion of the NCSACW technical assistance. In addition, the Core Team members have also noted that many activities, not specifically part of the IDTA work plan, are now carried out with greater interagency collaboration and coordination than in the past. They view the IDTA as the catalyst for all three systems to expand what was already an emerging collaboration.

Checklist of Major Components to be Completed During IDTA

Major Action Steps	Completion Date	Lead Committee/Workgroup/IDTA Staff or Consultants
LEADERSHIP & STAKEHOLDER ENGAGEMENT		
Confirm commitment from three lead agencies	1/15/09 application letter	Oversight Committee
Complete Collaborative Values Inventory (CVI)	12/31/09	Core Team; Consultant Liaison
Complete initial Collaborative Capacity Instrument (CCI)	6/15/10	Core Team; Consultant Liaison
Identify opportunities for linkages with other initiatives	Ongoing	Core Team; Consultant Liaison
Identify membership gaps and engage missing partners	Ongoing; most recent additions invited included: County Attorneys and Dept. of Education, who have joined. Still looking for someone from law enforcement to join.	Core Team ; Consultant Liaison
Finalize committee structures/memberships/meeting schedules	8/3/10	Core Team; Consultant Liaison
Conduct Kick-Off/Reach consensus on Identified Problem, Shared Goals and Outcomes	8/3/10	Oversight Committee; Core Team; Consultant Liaison
Finalize SOW and Establish Workgroups	10/10	Core Team; Consultant Liaison
Clarify and reach consensus on shared values and principles	Ongoing; Finalize 12/15/11	Core Team; Advisory Committee; Consultant Liaison
ASSESSMENT		
Determine the specific data/information needed to process effectively services and measure outcomes	4/11	Core Team; Data/Information Workgroup lead
Conduct pilot merges of CourtNET, TWIST, NOMS and START data; analyze results	12/1/11	Data/Information Workgroup lead
Implement plan/draft guidance on data collection and analysis coordination for tracking clients and systems outcomes, including identifying additional data/information required, based on the pilots.	7/1/12; Ongoing	Core Team; Data/Information Workgroup lead
Inventory program practices, strategies and modalities and tools: • Completed: o Screening and Assessment for : ▪ SUDS ▪ Child Maltreatment	Ongoing 3/1/11 Draft white paper 4/11;	Core Team; Practice Guide Workgroup chairs; Consultant Liaison

Major Action Steps	Completion Date	Lead Committee/Workgroup/IDTA Staff or Consultants
○ Drug Testing ○ Confidentiality and Information Sharing • To be completed (developmental work will be started): Child Removal and visitation, Engagement and Retention ; Transition Planning, Relapse & Recovery Support Services, Services for Children	currently under review by panel of judges Draft 4/11 Post TA	
Conduct Drop-Off Analysis	12/1/10	Core Team; Data/Information Workgroup lead
Conduct Virtual Walk-Through	4/12/11	Core Team
Regional Forums to engage stakeholders	12/1/11	Core Team; Consultant Liaison
Inventory agency and cross-agency training	5/1/11 inventory completed; priorities TBD	Core Team; Training Workgroup Chair; Consultant Liaison
Prioritize training, including NCSACW online trainings for staff in all three systems	In process: pending DCBS input and CEU/CLE confirmations Also, DCBS is conducting Drug Summits for staff through December 2011..	Core Team; Training Workgroup Chair'; Consultant Liaison
Inventory funding streams and opportunities; prioritize program enhancement and expansion possibilities. Develop a sustainability plan for supporting the integrated practice changes made and for future expansion possibilities.	6/30/11	Core Team; Sustainability Workgroup chair; Consultant Liaison
Review current treatment capacity to develop options to improve capacity via either policy/procedure changes or through their sustainability plan for increased resources.	In process, by county; completion 7/1/12	Practice Guide Work Group; Data and Information Work Group Chair; Consultant Liaison
Review most recent CFSR and PIP goals	Ongoing	Core Team; DCBS representatives
Identify opportunities for additional policy and practice changes beyond those currently prioritized (screening/assessment, drug testing and data matching).	Ongoing; discussed at last AC meeting 7/12/11	Core Team; Consultant Liaison
Report Out to Oversight Committee on findings	Ongoing, last AC meeting 7/12/11	Core Team
Mid-Point Assessment	12/13/10	Core Team, Consultant Liaison
Adjust SOW as needed	Ongoing	Core Team; Consultant Liaison
PLANNING AND DEVELOPMENT		

Major Action Steps	Completion Date	Lead Committee/Workgroup/IDTA Staff or Consultants
Prioritize and select additional policy and/or practice changes for each system	Ongoing; major priorities set by 4/12/11	Core Team; Oversight Committee; Consultant Liaison
Product development/revisions (specify)		
• MOU for continued collaboration, including ongoing agreements on implementing the practice guide, data and information sharing, and training.	Draft developed; 6/1/12	Core Team, Consultant Liaison, Oversight Committee
• MOU (draft) for data sharing between KY Court, CATS and TWIST following testing through pilot data merges	2/1/12	Practice Guide Work Group; Data and Information Work Group Chair
• Practice Protocol(s) o Screening and Assessment for SUDS o Screening for Child Maltreatment o Drug Testing o Cross Agency Information Sharing and Data Protocol, including confidential information	Drafts developed; Finals 6/1/12	Core Team, Work Group Chairs, Consultant Liaison
• Statewide Assessment of Need & Best Practices based on results of the Regional Forums and a plan for how best to address needs, issues and best practices identified.	4/1/12	Core Team, Data and Information Sharing Work Group
• Work within each system and across systems to adapt/adopt products and embed into practice	6/12	Core Team, Consultant Liaison
• Sustainability Planning and Advisory Recommendations	Under development; 7/12	Core Team, Consultant Liaison
Review of Ongoing Implementation Plan by the Advisory Committee and the Oversight Committee	6/12	Oversight Committee, Advisory Committee, Core Team and Consultant Liaison
Approval for Ongoing Implementation Plan	7/1/12	Oversight Committee Core Team;
TESTING AND IMPLEMENTATION		
Products tested and implemented:		
• *Drug Testing White Paper*	Draft 4/6/11; Final 2/1/12	Core Team; Practice Guide Workgroup Chairs, Nancy Hansen (NCSACW), Consultant Liaison
• *UNCOPE Pilot in 7 Counties* • *UNCOPE Implementation*	11/1/11 4/1/12	Core Team; Practice Guide Workgroup Chairs, Consultant Liaison
• *Draft Practice Guide Sections on Screening for SUDs and child maltreatment, drug testing, and information sharing for final review/sign off*	Draft 6/1/12; Final post-TA	Core Team; Practice Guide Workgroup Chairs, Consultant Liaison
• *Information Sharing Practice Guidelines*	Draft 7/1/12; Final 6/1/12	Core Team; Data/Information Sharing Workgroup Chairs

Major Action Steps	Completion Date	Lead Committee/Workgroup/IDTA Staff or Consultants
• *Ensure IDTA-identified best practices become embedded in standard operating procedures for each agency, e.g., contracting, licensing,*	6/12 and post-TA	Core Team; Oversight Committee; Consultant Liaison
Final Signed Practice Guide Sections (Screening and Assessment, Drug Testing, Child Removal, Permanency and Visitation). Other sections in draft.	6/1/12	Core Team; Oversight Committee
Final Marketing and Implementation Plan to facilitate adoption/adaptation of products developed	Draft 7/1/12; Final Post TA - 8/1/12	Core Team; Oversight Committee
Determine what training would support implementation and develop final Training Delivery Plan	Draft 7/1/12; Final Post TA - 8/1/12	Core Team; Oversight Committee
Protocol Rollout and Monitoring Plan	Draft 7/1/12; Final Post TA - 8/1/12	Core Team; Oversight Committee
Follow-up CCI	5/12	Core Team
Follow-up CVI	5/12	Core Team
Report Out to Oversight Committee on findings	7/12	Core Team
Report Out to Advisory Committee on findings	7/12	Core Team/Oversight Committee

Part 2 is the power point developed from the IDTA.

KY DCBS Drug Summits:

Child Welfare Decision Making With Substance Abusing Families

Fall 2011

Housekeeping Issues

- Did you sign in today? Did you pick up your training materials?
- Only travel and lodging should be coded to HZZFAP
- Respect your neighbor. No sidebar conversations please!
- Please put you phones on "vibrate"
- Agenda Overview
- Breaks are built into the agenda
- One hour for lunch

2

Thank You!!!

- Casey Family Programs
- Eastern Kentucky University
- START Team
- Dave Hopkins,KASPER
- Drug Enforcement Administration, DEA
- National Association of Drug Diversion Investigators, Inc. (NADDI)
- Substance Abuse and Mental Health Services Administration, (SAMHSA)

3

Introductions

- *Tina M. Willauer, MPA, Director, Sobriety Treatment and Recovery Teams (START)*
  Department for Community Based Services
  - *Tinam.Willauer@ky.gov*
- *Debbie Acker, RN, CFN, Nurse Service Administrator,*
  Division of Protection and Permanency,
  Department for Community Based Services
  - *Debbie.Acker@ky.gov*

- *Steve Hartwig, MS, MSW, Child Protection Specialist*
  Child Safety Branch
  Department for Community Based Services
  - *Steve.Hartwig@ky.gov*

4

Introductions

- *Jeanne Keen, MS, RN, ICADC, Program Administrator*
  Family Violence Prevention Branch
  Department for Community Based Services
  - *Jean.Keen@ky.gov*
- *Lisa Durbin, MSW, CSW*
  Child Safety Branch Manager
  Department for Community Based Services
  - *LisaA.Durbin@ky.gov*

5

What We Will Cover Today

- Values and beliefs about families with co-occurring substance use disorders and child maltreatment.
- Substance Use, Abuse and Dependency.

- Drugs of abuse and drug testing.
- How good family engagement, case planning, relapse planning and collaboration with treatment providers through out the life of a case can help improve outcomes
- Prevention planning and case planning with families who have substance abuse as a risk factor.

6

Before We Get Started...

- Quiz on Substance Use, Child Maltreatment and Our Values and Beliefs, Drugs of Abuse and Drug Testing
- Video: "Children At Risk"...by the National Alliance For Drug Endangered Children

NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN

7

CHILDREN AT RISK

www.nationaldec.org

8

Substance Use and Child Maltreatment

9

Substance Use and Child Maltreatment

- Children of substance abusing parents are three times more likely to be abused and over four times more likely to be neglected than children of caregivers who are not substance abusers. *(Reid and Foster,1999).*
- Nationally, 50% of substantiated reports for child abuse and neglect involve parental substance abuse *(NCSACW, 2004).*

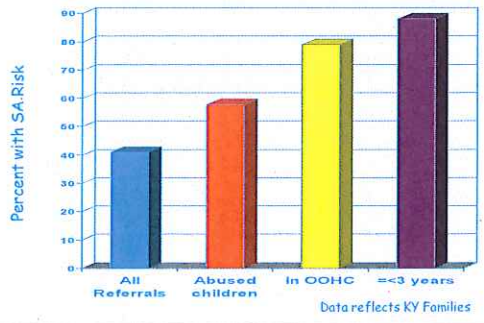
10

Substance Use and Child Maltreatment

- Maltreated children of substance abusing parents remain in the child welfare system longer and experience poorer outcomes *(GAO, 2003).*
- Alcohol and drug use are often under-recognized as a factor in child welfare cases *(NCSACW, 2004).*

11

Substance Use as a Risk Factor To Children: A State and National Problem



12

Action Step 1B.2.1 part 2
KY 7th QR PIP report
December 31, 2011

Status Quo: All Three Systems

- The three systems are largely independent.
- CPS refers to addiction services with concerns that clients will access the service in time or have the means to comply.
- Courts may order services, but services must be accessible, of high quality with appropriate level of care provided.
- Concerned that family will fail and children will require removal.
- Families with addiction struggle to structure their lives and comply with numerous plans.
- Children are either in chronic risk/neglect situations or in foster care.
- The family's strengths and involvement are overshadowed by the perception of addiction.

13

Status Quo: All Three Systems

- CPS is focused on the child. Addiction services are focused on the adult. Courts want action and child safety.
- The family must comply. The law enforcement approach may prevail.
- Drug testing is used as a single measure to make decisions.
- There is lots of tension in what is valued.
- There is mistrust and second guessing decisions by all parties involved.
- There is overlap between roles (i.e. what level of care is needed, questioning removals or non-removals).
- Clarification of best practice.
- Not enough treatment services to meet the needs.
- Court dockets are full; judges need cross system and comprehensive information to make judgments.

14

Desired System

- Child welfare, treatment providers, courts, and community partners effectively collaborate
- Child and adult safety, permanency, and well-being are shared desired outcomes
- Families collaborate and participate
- Strength-based and reality based practice
- SA treatment needs to be evidence-based
- Program evaluation is integrated as a change agent; cross system data sharing.

15

Desired System

- Family has quick access to treatment and supports for retention in treatment
- Maximum strength of intervention - families have opportunities and persistence through relapse
- Families/Parents improve capacity to parent
- Children are safely maintained at home return home from OOHC in a timely manner

16

Barriers Families Face

17

June 2009 In-Home DCBS Services Staff (655) Survey

If a caretaker has a positive drug screen, then the children should be removed.

- 12% agree or strongly agree.
- 39% are neutral.
- 49% disagree or strongly disagree.

I am discouraged in working with families that have chronic recurring child neglect issues.

- 39% agree or strongly agree.
- 28% are neutral.
- 33% disagree or strongly disagree.

My knowledge of how to develop a relapse plan

- 49% ranked this as a mild barrier

18

The Five Clocks Facing Families, Providers and CPS

- Adoption and Safe Families Act (ASFA)
- Temporary Assistance to Needy Families (TANF)
- Child's developmental timetable
- Recovery process and substance abuse treatment
- Time for staff to respond to the other four clocks

19

ASFA Timeframes v. Substance Abuse Treatment Realities

- Treatment slots are not always available
- Treatment may take many months
- Lack of programs that allow children to live in the facility (if child has not been removed)
- Lack of coordination between service systems make it difficult to address family/children's needs
- Delayed permanency decision for children in the foster care system
- Children may be less likely to reunify with caretakers in greater numbers than children from non-substance abusing families

20

Barriers to Accessing Treatment

- Expense
- Family responsibilities
- Job responsibilities
- Waiting lists
- Location - leaving home or their region
- Perception that "I am not like those drunks/druggies/addicts"
- Perception that it has failed in the past and won't work
- Perception that "I can get off drugs on my own"

21

Complicated Families

- Addiction frequently co-exists with
  - Domestic violence
  - Poverty
  - Mental health problems
  - Trauma histories
  - Criminal behavior
  - Dysfunctional relationships
  - Inadequate health care
  - Poor nutrition
  - Child welfare history

22

Other Complications for Women

- Women in substance abuse treatment
  - More educational deficits
  - Lower employment rates
  - Lack employment skills
  - Fewer economic resources
  - More likely to be single or divorced
  - Financial burden of children
  - Transportation and childcare issues
  - Some cannot afford treatment

Wechsberg (1998), Moran (1998), Oggins, Guydish, & Delucchi (2001), Gregoire and Snively (2001)

23

Angela's Story

24

Families in the CPS System

- Childcare schedules and availability (making sure that services are provided during times when child care is available)
- Visitation schedules (allowing clients to have visitation, which is important for reunification)
- Work requirements for public assistance
- Sober parenting issues (training and education)
- Multiple other appointments: medical and mental health providers, etc. (allowing time for excused absences)

25

Other Barriers

- Fiscal climate/funding
- "Business as Usual" culture
- Medicaid does not pay for SA treatment in KY
- Managed care will be a game changer for behavioral health services.
- Lack of substance abuse treatment resources/long waiting lists
- History of working independently from other systems (CPS, Behavioral Health, Courts)

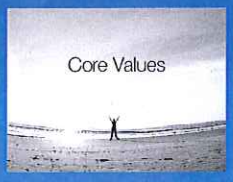
26

So Why Do We Do This Work?

27

Values and Beliefs:

Checking Our Lenses



28

Values are like fingerprints.... Nobody's are the same but you leave them all over everything you do.

-Elvis Presley

29

Beliefs

Studies show clearly that **our beliefs can determine the way things turn out.** They're not "mere thoughts"; they're instructions. Believing something sends a psycho-neurological message through your entire mind/body system that seeks to make it happen.

(http://www.sciencedaily.com/releases/2007/12/071212202008.htm)

30

"Perception is Reality"

What do you see?
By shifting perspective you might see an old woman or a young woman.

31

Voices Say

"They don't want help."

"The problem is too big."

"Those children are doomed."

"If she loved her kids, she'd stop."

"They don't deserve to be mothers."

"Treatment is a waste of time."

Common Assumptions About Substance Use and Parenting

- Addiction is voluntary behavior
- It's a choice not a disease
- Social or moral problem; Character flaw
- If addicted parents really loved their children they would stop using drugs
- A CPS investigation should be enough for a parent to "get their act together"
- Treatment just doesn't work; Hopeless cause
- Why can't they just stop using?

33

Challenging Stigma

- Addiction: A chronic brain disorder/disease characterized by compulsive drug craving, seeking and continued use despite adverse consequences.
- No population group is immune to the effects of substance abuse and addiction.
- The entire family needs treatment and support!

34

The brain controls feelings, behavior, and habits.

Addiction changes the chemistry of the brain.

Behavior is VISIBLE; we assume behavior = character.

Addiction is a brain disease/disorder, not a weak will. The disease of addiction causes changes in brain chemistry. These brain changes directly affect thinking, judgment, planning, sequencing, memory...

Does this mean parents don't love their children?

However, there is an impact on children...

- Chaotic and unpredictable home life
- Inconsistent care; basic needs not met; lack of supervision
- Dangers of drug using environment
- Emotional maltreatment; guilt, shame and secrecy
- Behavior problems at home and school
- Prenatal substance abuse; Fetal Alcohol Spectrum Disorders
- Developmental delays
- Issues with trust, self-esteem and attachment
- Child substance abuse

NCSACW, 2004

36

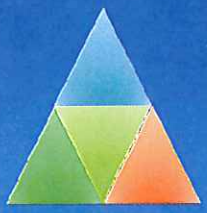
Challenging Stigma

- Substance abuse is a serious risk factor for child safety but...
- Screening, holistic assessment and treatment can lower risks to children.
- Some children living with adults with substance use disorders can remain safely in the home.

37

They've already gone to treatment and it didn't work. What's the point of sending them again?

We used to believe that the first five times were failures and the sixth time was a success.



Now we know that the sixth time worked because of the first five. Different people require different dosages of treatment.

"If parents loved their kids, they would stop using."

becomes

"They love their kids AND they have the disease of addiction. How can we engage the family and support them to overcome their addiction and still protect the children??"

Values and Decision Making

- Even though we intend to help families, we must always consider how our values and judgments are affecting our decision making.
- Check values and personal "baggage" at the door.

40

Values and Decision Making

- Engage families and show empathy.
- Avoid authoritative or punitive approaches.
- We must change our way of thinking about families who have SUDs and child maltreatment .

- And remember..... this is not about us!!

41

Understanding SUDs and Recovery

- Become educated about substance use disorders
- Go to trainings and read about SUDs.
- Attend a 12 step meeting or other recovery support meeting.

- Read the AA Big Book or NA text book.
- Talk to a recovering person about addiction and recovery.
- Identify your own biases and be honest about it.
- Work through your personal issues and baggage.

42

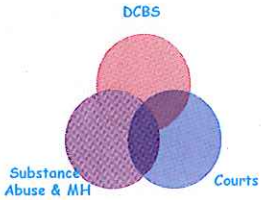
Addressing the Problem …

- Paradigm shift and new way of doing business
- Requires us to think differently about SUD's.
- Innovations in child welfare practices
- Evidence based practice in SUD treatment
- More focus needed on the specific issue of substance abuse and child maltreatment
- Family Centered, strength based practice
- Integrated service delivery system of care
- Improved cross system collaboration between CPS, Courts , substance abuse providers and community

43

Three Key Systems

- Co-occurring substance abuse and child maltreatment demands collaboration and quality care from systems charged with promoting child safety and family well being.
- No one system, agency or entity has the resources needed to effectively address this problem



SAFERR Model, NCSACW

44

Substance Use Disorders SUDs

45

Substance Use Disorders (SUDs)

- Terminology is evolving and changing as we learn more about this brain disorder/disease.
- Includes the diagnoses of Substance Abuse and Substance Dependence in DSM-IV.
- Also known as alcohol or other drug (AOD) problem, drug abuse, substance abuse, alcoholism, drug dependence, addiction.

46

Alcohol and Drug Use Continuum

- Alcohol and drug use occurs along a continuum- use, abuse, dependency
- Not everyone who uses substances abuses or is dependent on them.
- Full assessment is needed for accurate diagnosis and treatment recommendation.
- All levels of substance use can have implications for child safety.

Breshears & Young, 2004

47

Spectrum

- Use: social, recreational, occasional
- Abuse: negative consequences but continue to use substance
- Dependence/Addiction: negative consequences PLUS
  - ✓Tolerance
  - ✓Withdrawal
  - ✓Compulsive use

48

Addiction

- Chronic
- Often relapsing
- Brain disorder
- Causes compulsive drug seeking
- Causes use despite harmful consequences
- Changes the structure and function of the brain

49

Choice?

- Initial decision to drink or use is voluntary
- Over time, changes in the brain caused by repeated use can impact
  - self-control
  - ability to make sound decisions
  - PLUS, causes intense cravings

- People who abuse drugs can stop more easily, but they may not think they have a problem!
- People with addiction can choose to stop, but it is hard work, and some are not successful

50

The Reward Circuit

- The limbic system has to do with survival (eating, spending time with loved ones)
- Drugs flood the brain with DOPAMINE in the LIMBIC system - part of the brain that controls
  - Movement
  - Emotion
  - Motivation
  - Feelings of pleasure

51

Reward Circuit...

- Drugs cause euphoria or a "high"
- This brain response "teaches" people to repeat the behavior of using/abusing drugs
- Then the brain stops making its own dopamine and the receptors get damaged, so you need more drug to get high
- Now you need the drug to feel normal

52

Addressing Co-Occurring Substance Use and Child Maltreatment

Strategies and Protective Factors

Considerations When Substance Use is a Factor

- How does the substance use affect the caregiver's ability to make sound judgments about the welfare of the child?
- What behaviors are resulting from the caregiver's substance use?
- Consider safety and risk factors.

54

Considerations When Substance Use is a Factor

- What are the protective factors?
- Using drug testing in the decision-making process.
- Wrap around services and creative planning with families.
- Visitation between children and parents.

Other Considerations...

- Willingness of parent or caregiver to admit substance use
- Willingness of parent or caregiver to undergo comprehensive substance use disorder assessment and get treatment if needed.
- Availability of treatment services in the region.
- Available safety interventions and supports for the family.

56

Family Centered Practice

- Families seen as partners in change instead of recipients of services.
- Strength-based not deficit-based.
- Collaborative team approach including family, treatment providers, CPS, courts, community and other formal or informal supports.

57

Family Centered Practice

- Make engagement and partnership the "cornerstone" of CPS practice (research indicates this approach yields better outcomes).
- Solution-focused partnerships with clients tends to increase both worker and client investment.

58

Engaging Families

- Non punitive, non authoritative approach.
- We are not the police!
- Provide families choices when possible.
- Give clear and specific direction/expectations.
- Involve families in their own planning.
- Your attitude matters!!
- Show empathy
- R-E-S-P-E-C-T
  - Communication goes both ways
  - Words matter
  - Body Language
  - Empowerment vs. Disempowerment

59

It's All About Relationships!!

Communication
Trust
Respect
Empathy
Engagement
Collaboration

Better chance for success!!!

60

Relationships and Hope

Don't underestimate the importance of your relationship with families!! It makes a huge difference in the family's ability to succeed!!!

61

Strategies That Helped...

- They were fair and honest with me. That's why I was fair and honest with them.
- I never knew about addiction, but they taught me what addiction is, what it does to you in the long run, how it changes your brain and how to recover.
- It's hard to stay sober in a substance abusing community. They helped me learn that addiction is a disease, and how to deal with the substance abusers around me. We relapsed several times, but they keep working with us and helping us stay sober longer.

62

Can People Get Better?

- Yes! Recovery is possible!
- What helps?
  - Self-help meetings (AA, NA, SAVE, Celebrate Recovery etc.)
  - Treatment
  - Support of family, friends, professionals
  - Straight talk
  - Mandatory treatment (court-ordered)
  - Being on the same page as a team
- Many do recover, but addiction is a serious problem, and some people will die from it.

63

What Does Not Help?

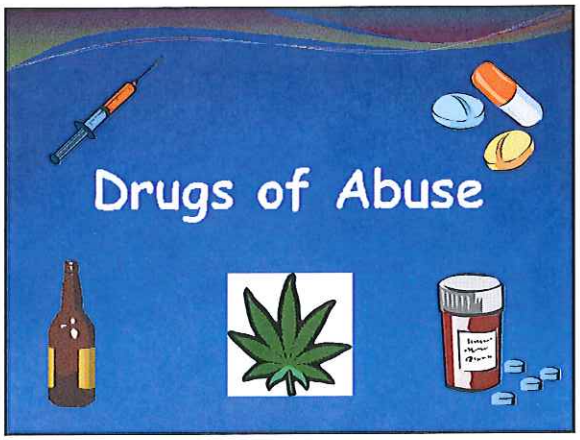
- Judgment ("you're a bad person," "you'll never get better," "you'll never be a good parent")
- Minimizing or ignoring the problem
- Authoritative approach
- Yelling, threats, hiding the drugs
- Punitive, angry approach to the problem

64

Final Thoughts...

- You can be hopeful that parents will, with the right supports, get into recovery
- Also be realistic: not everyone recovers from addiction
- Accountability is VERY important to recovery
- Judgment, punishment, and resentment are ineffective
- Families do heal!

65



Alcohol - a CNS Depressant

- Alcohol is a drug. The most common drug used in the United States. It can be addictive.
- Ten percent of people who use alcohol will become alcohol dependent.
- Alcohol affects every organ in the body.
- Withdrawal can be life threatening.

A drink is a drink is a drink...

Effects of Alcohol

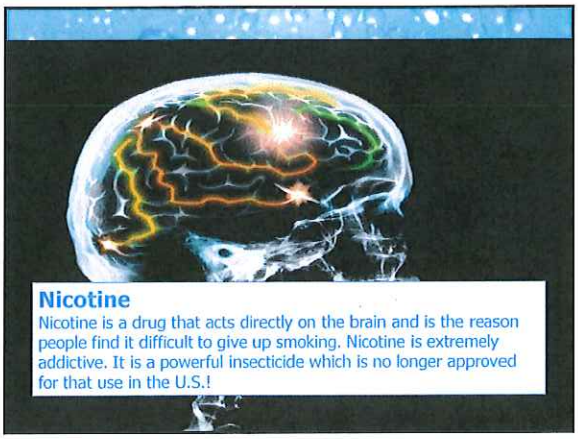
- Dose Dependent - from comical to coma
- Alcohol crosses the placenta
- Drinking alcohol while pregnant is a major cause of mental retardation and is completely preventable. There is no safe time or safe amount of alcohol for a pregnant woman to drink.
- **Just because it's legal doesn't mean it's safe!**

Did you know?

Pregnant women and intravenous drug users are a priority population for substance abuse treatment.

Treatment programs in Kentucky that receive block grant dollars - all CHMCs and their contractors - are required to admit pregnant women, pregnant IV users, and other IV users immediately for services or to put them on the top of the waiting list. If placed on the waiting list, interim services should be provided.

Tobacco



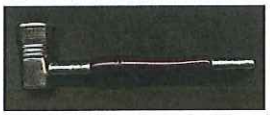
Marijuana

- Most often used illegal drug in the United States
- Leaves and flowers of the hemp plant *Cannabis sativa*
- Other names include "pot" "grass" "hash" "weed" "Mary Jane" "reefer" "skunk"
- *Marijuana is fat soluble so it stays in the system about thirty days.*

Marijuana

Marijuana

Cannabis leaves



Cannabis pipe

CNS Depressants - Benzodiazepines

Benzodiazepines

(Benzos, Nerve Pills, Candy, Tranks)

- Benzodiazepines are depressants and used for their tranquilizing and anti-anxiety effects.
- Medical uses
  - anti-anxiety
  - muscle relaxants
  - anesthetic adjuncts
  - Anticonvulsants
  - obsessive/compulsive disorders

Most widely prescribed class of medication today - and most abused.

Commonly abused Benzos

- Alprazolam (Xanax)
- Diazepam (Valium)
- Clonazepam (Klonopin)
- Lorazepam (Ativan)
- Oxazepam (Serax)
- (Triazolam) (Halcion)

Benzodiazepine Effects

- Slows down the CNS leading to drowsiness, calming effect
- Similar to alcohol intoxication, dose related. Can lead to extreme sedation, coma and death
- Muscle relaxation
- Impaired coordination
- When combined with alcohol and other CNS depressants there is a synergistic effect
- Withdrawal can be life threatening.

"Club drugs"

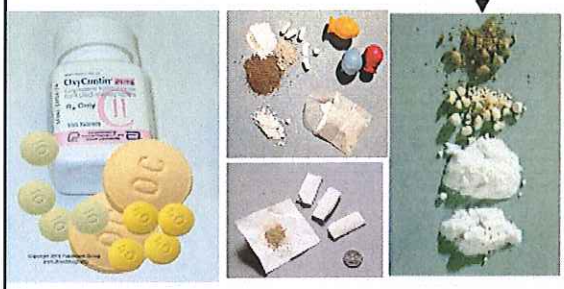
Rohypnal - Roofies

GHB in vials

Club Drugs (Benzodiazepines)

- Rohypnol (Flunitrazepam)
  - Date rape drug (frequently called "Roofies")
  - Added to alcoholic beverage to enhance effects - amnesia and time disorientation
  - Effects last 4 - 8 hours
  - Look for drunken-like state
- GHB (Gamma-Hydroxybutyric acid)
  - Used at raves and is also known to be a date rape drug (called Georgia Home Boy, Liquid X)
  - Hypnotic, anesthetic, effects last 3 - 6 hours
  - Usually in liquid form, has no smell or taste
  - large amounts may lead to coma

Central Nervous System Depressants: Opioids



Opioids (Narcotics, Opiates)

• Opium	Aunti, Big O
• Heroin	H, Horse, Smack
• Morphine	Dreamer, Morf, God's Drug
• Codeine	School boy
• Oxycodone	Hillbilly Heroin, OC, Oxycotin
• Hydrocodone	Hydro, Tabs, Vikes , Lortab
• Hydromorphone	D, Dillies, Dust, Juice, Dilaudid
• Methadone	Fizzies, Wafer

1887 Ad for the opiate morphine

Mrs. Winslow's Soothing Syrup

Mrs. Winslow's Soothing Syrup was an indispensable aid to mothers and child-care workers. Containing one grain (65 mg) of morphine per fluid ounce, it effectively quieted restless infants and small children. It probably also helped mothers relax after a hard day's work. The company used various media to promote their product, including recipe books, calendars, and trade cards such as the one shown here from 1887 (A calendar is on the reverse side.).

How Opioids Work:

- Opioids attach to pain receptors in the CNS thereby blocking the users' perception of pain.
- They also induce a euphoric "high" followed by a general feeling of relaxation and well-being.
- Chronic use can lead to tolerance, dependence and withdrawal.

Method of Use

- Swallowed - pills
- Smoked – opium, heroin
- Snorted – heroin, pills
- Injected – heroin, oxycodone, hydromorphone, opium
- Patch – for long term pain relief , Fentenyl

- Look for: medicine bottles, pills, white to dark brown powder, syringes, needles, bent spoons, tracks.

What to look for:

- Pin point pupils
- Euphoria
- Drowsiness
- "Nodding"
- Lethargy
- "Tracks" on arms
- Flu like symptoms if withdrawing

Medication-Assisted Treatment (MAT)

- MAT is a treatment for opioid addiction, used since the early 1970's, that uses medications to block the euphoric effects of opioids and relieve the physiological craving.

- There are two medications being used – Methadone and Buprenorphine (Subutex). Both of these drugs are synthetic opioids.

Differences

Methadone

- It has been in use since the early 1970's
- Prescribed only by treatment program for addiction
- Taken orally

Suboxone

- Available for opioid treatment in 2002
- Can be prescribed for addiction by a specially licensed physician or a Treatment Program.
- Taken by pill or film form which melts under the tongue

Main difference is not the medication but the prescriber. A MAT program involves counseling, UDS and monitoring. A licensed physician may not.

How MAT works:

- Methadone attaches to the same pain receptors in the CNS that opioids do which eliminates craving
- They block other opioids from attaching to the receptors which prevents the client from getting "high"
- They have the same pain relieving properties but do not produce the same euphoric effects.
- They last longer – 24 hours.
- They are legal which reduces criminal activity.
- They are taken orally which eliminates use of needles and risk of disease.

It's not substituting one drug for another – it's substituting one lifestyle for another.

MAT and Pregnancy

- Recommended for opioid dependent pregnant women since early 70's
- *NIH recommended MAT as standard of care for pregnant women in 1997*
- Pregnant opioid dependent women are a priority population for MAT
- Prevents erratic opioid levels and protects the fetus from episodes of withdrawal

MAT and pregnancy, continued

- Reduces incidence of maternal and fetal complications
- Reduces fetal exposure to other drug use
- Increases prenatal care and compliance
- Decreases risk to fetus of infection(Hep C, HIV, etc.)

Central Nervous System Stimulants

Cocaine

- Most powerful natural stimulant, synthesized from the leaves of the coca plant found primarily in South America.
- Gives the user a feeling of euphoria, confidence and power
- It is extremely addictive
- Also called Coke, Snow, Nose Candy, Dust, White Lady, Toot, Blow

Cocaine and Crack Cocaine

- Cocaine can be a powder form that is normally snorted or dissolved in water and injected
- Or can be in a rock form which is generally smoked and is the most addictive form or cocaine

The term "crack" refers to the crackling sound produced by the rock as it is heated.

How Cocaine Works

Cocaine acts on the pleasure circuit in the brain to prevent the re-absorption of dopamine. This causes a build up of dopamine which makes the user feel euphoric.

When dopamine level returns to normal the user feels an intense craving to use cocaine again. Withdrawal can be severe.

Remember – it's a brain disease!

Effects of Cocaine:

- Dilated pupils
- Dry mouth
- Tremors or twitching
- Hyper-alertness/paranoia
- Lack of fatigue/sleeplessness
- Panic
- Extremely talkative
- Fast speech
- Runny nose or bloody nose
- Seizures from high doses or bad reaction

What to look for

- White powder seen on face or clothes
- Small spoon-like items used for snorting
- Mirrors and razor blades used for making lines
- Rolled money bills used for snorting
- Small bottles with screw on lids for storing
- Possession of small plastic packets with white residue
- Needles, syringes, bent spoons

Stimulants – Amphetamines

- Examples – Ritalin, Adderall, Dexedrine, methamphetamine
- Amphetamines speed up the body's system. Many are legally prescribed and used to treat ADHD
- Street names – Bennies, Black Beauties, Crank, Ice, Speed, Uppers
- Methods of use – Oral, injected or smoked (meth)
- Effects – similar to cocaine but their onset is slower and the effects last longer
- Withdrawal can be severe

Ritalin (Methylphenidate)

- It isn't just for children with Attention Deficit Disorder any more
- It is a Central Nervous System Stimulant
- Also called "Kibbles and Bits" and "Pineapple"

Name this drug!

- Lithium Batteries
- Ephedrine
- Paint Remover
- Hydrochloric Acid
- Drain Cleaner
- Ammonia
- Bleach
- Gasoline

Methamphetamine (Meth)

- Chemically similar to adrenaline.
- Stimulates the central nervous system to produce more of the "feel good" hormone, dopamine.
- It is highly addictive.
- Produces short, intense rush that is followed by a sense of euphoria and invulnerability lasting up to 8 hours.
- *Made with cold pills, solvent and metals; processed with other household chemicals.*
- Can be smoked, snorted, injected, or swallowed.

Signs of Meth Use

- Small amounts of methamphetamine consumption can result in many of the same physical effects as those of other stimulants, such as cocaine or amphetamines:
  - increased wakefulness
  - increased physical activity
  - decreased appetite
  - increased respiration
  - rapid heart rate
  - irregular heartbeat
  - increased blood pressure
  - hyperthermia

Look for sweating, tremors, dry mouth and sores on the face

Meth Effects

- Long-term methamphetamine abuse has many negative health consequences
  - extreme weight loss
  - severe dental problems ("meth mouth")
  - anxiety
  - confusion
  - insomnia
  - mood disturbances
  - violent behavior
- Chronic methamphetamine abusers can also display a number of psychotic features
  - paranoia
  - suicidal and homicidal ideations
  - visual/auditory hallucinations
  - delusions (insects crawling under the skin)

Faces of Meth

Faces of Meth

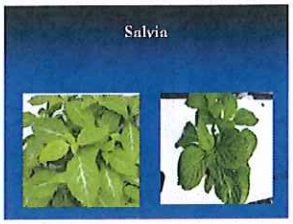
Hallucinogens

Examples of Hallucinogens

- LSD – acid, microdot, hits
- PCP – angel dust, rocket fuel
- Psilocybin – shrooms, caps, magic mushrooms
- Mescalin – peyote, buttons, cactus
- Kettamine – special K, vitamin K ("club drug")
- MDMA – ecstasy, X, the love drug
- Salvia – Mexican Marijuana, Weeds, Diviner's Sage

Salvia

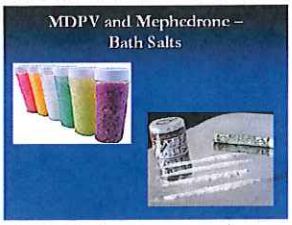
- Used by Mazatec Indians in rituals
- In the mint family
- Found in Mexico
- Lasts only 2 to 5 minutes



Salvia

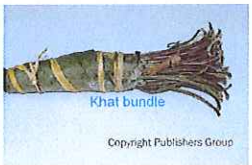
- It can be smoked, chewed or vaporized
- Psychic effects include vivid colors, shapes and body movement and bright lights.
- Can also cause fear and panic
- Uncontrollable laughter
- Can cause loss of coordination, dizziness and slurred speech
- Illegal in KY since 2009

Bath Salts



Bath Salts (Mephedrone)

Synthetic stimulant made from Cathinone which is a chemical found in the Khat ("Cot") plant.



Bath Salts

- Found in many retail products and sold in convenience stores, head shops, internet
- Street names – Bliss, Cloud Nine, Vanilla Sky, White Dove
- Sold in powder form in small packets , capsules and tablets
- Usually ingested by inhalation but can be used orally, smoked or IV

Bath Salts

- High is similar to cocaine, Khat, LSD, and MDMA
- *Effects include agitation, depression, paranoia, delusions, hallucinations, suicidal thoughts and seizures*
- Some users report bad "trips"
- Intense cravings after use
- Illegal in 32 states, including Kentucky
- Long term effects are unknown

Spice, K2

- K2 or Spice is a mixture of herbs and spices that is sprayed with a synthetic chemical similar to THC.
- It is sold in small plastic bags and found in head shops, other outlets or over the internet.
- Known as Fake Weed, Black Mamba, Genie
- Usually smoked but some users make tea

Spice - Effects

- Psychological effects are similar to marijuana
- Physical effects can include:
  - Elevated blood pressure
  - Racing heartbeat
  - Visual disturbances
  - Anxiety
  - Stroke
  - Seizures
- Banned since March 1, 2011

Web Resources

National Institute on Alcoholism and Alcohol Abuse
http://www.niaaa.nih.gov/

National Institute on Drug Abuse
http://www.drugabuse.gov/

Drug Enforcement Administration
http://www.usdoj.gov/dea/index.htm

Partners for a Drug-Free America
http://www.drugfreeamerica.org/

What is a drug test?

- a technical analysis of a biological specimen to determine the presence or absence of specified parent drugs or their metabolites.

Substance Abuse & Mental Health Services Administration

What Questions Can Drug Testing Answer?

- Whether an individual has used a tested substance within a detectable time frame

What Questions Can Drug Testing *Not Answer?*

- A drug test alone cannot determine the existence or absence of a substance use disorder
- The severity of an individual's substance use disorder
- Whether a child is safe
- The parenting capacity and skills of the caregiver

What can be tested?

- Urine
- Oral fluid
- Sweat
- Hair
- Breath
- Blood
- Meconium

Specimen Sources and Window of Detection

- Urine (detects consumption past 72 hours)
- Oral fluid (detects consumption up to 2 -4 days)
- Sweat (detects consumption up to 1 - 4 weeks)
- Hair (detects consumption up to 4 - 6 months)
- Breath (detects consumption up to 12 - 24 hours)
- Blood (detects consumption up to 12 - 24 hours
- Meconium (detects consumption last half of pregnancy)

7/1/11

Screening Drug Test (Immunoassay)

- This is the most often used Screening Test
  - Requires small amount of specimen
    - Typically Urine but almost any biological can be tested
      - Biological means from the body
  - Very sensitive
  - Subject to interference and interpretation
    - Not 100% reliable
  - Used to detect "family or type" of drugs

So what does this mean...

- Decisions should not be made on a drug test alone.

Therefore...

- The first step in screening for substance abuse is a good assessment to determine if interventions should be considered.
  - Are the parent's behaviors creating safety or risk issues for the children?
  - Is there a history of substance abuse?
  - Do I actually need a drug test?
  - What is a drug test going to tell me?

SO...

- How do drug test results effect our next steps?
  - It provides limited information regarding what was in the person's system at a specific period of time.
  - It does not provide insight into behaviors, physical or mental impairment, or parental capacity.

Remember...

A drug test is a snap shot in time—it tells you what drug was taken and when it was in a person's system.

"You're fired, Jack. The lab results just came back, and you tested positive for Coke."

Let's take a minute to think of a time when you were in an Emergency Room setting.

- What did you see?
- Now focus on a patient with the following symptoms arriving at that Emergency Room:
  - Sweating
  - Nausea/Vomiting
  - Abdominal Pain
  - Fast Heart Beat
  - Confusion

What Happens?

Doc Examines Patient	SSW Conducts Assessment
Observations & questions	Observations & questions
Doc speaks to the family in the waiting room	SSW interviews household members & collaterals
Doc secures/reviews the past medical records	SSW gathers documentation/reviews (AOC, TWIST, etc.)
Doc may consult a Specialist	SSW consults with FSOS/Specialist
May consider laboratory testing	May consider securing a drug test

How do we then screen for substance abuse issues?

By....

- Reviewing AOC Checks
- Reviewing prior agency CPS and APS reports for indications of substance use or abuse and consider
- Interviewing children/spouse/paramour/significant others/household members, and collaterals.
- Observing the parents behaviors, appearance and the home environment.

Strategies in Your Packet

- Criteria To Help You Screen For Substance Abuse Issues in:
  - Investigations
  - FINSAs
  - Ongoing Cases

How to Use this Information:

- Share it with your FSOS when you staff a report so that together you both make sound decisions.
- Utilize it in your CQA under Adult Patterns of Behavior by summarizing what you have collected about the parent's behaviors.
- Place it in court reports so that you can present a detailed picture of the family to Court personnel
- Share it with providers so they also understand family dynamics when they are completing assessments or providing services to the family.

Remember

- We have an ethical obligation to provide the Court with a comprehensive assessment of the family and to clearly articulate what our agency recommendations are to keep children safe and to advocate for these during court appearances.
- The Court then uses this information to render their decisions, which may or may not be what we recommended.

Case Walk Through:

The Jones Family Case Scenario

Assessing The Situation

Identifying Safety Factors, Risk Factors and the Protective Capacity of the Jones Family

Safety

Refers to the absence of "present or impending danger" to a child or sufficient caregiver protective capacities to assure that a child is protected from danger.

http://www.actionchildprotection.org/

Risk of Maltreatment

- Refers to the likelihood of future maltreatment; that parenting behavior will be harmful or destructive to a child's cognitive, social, emotional and/or physical development and those with parenting responsibility are unable or unwilling to behave differently.

http://www.actionchildprotection.org/

Caregiver Protective Factors

- Refers to personal and parenting behavioral, cognitive and emotional characteristics that can specifically and directly be associated with a person being protective of his or her child.
- It is a specific quality that can be observed, understood and demonstrated as a part of the way a parent thinks, feels and acts that makes him/her protective of his or her child.

http://www.actionchildprotection.org/

The Jones Family Scenario

- Read case scenario
- Break into small groups/one person to scribe
- Answer the following questions:
  - List safety factors
  - List risk factors
  - What are the protective capacities of the caretakers?
  - Who are the collaterals you would talk to?
  - How would you engage this family?

Determining the Drug or Alcohol Connection During a CPS Investigation

- Drug and Alcohol Involvement should always be considered and explored.
- In home assessment is needed.
- Holistic Assessment-Use of a variety of sources to obtain information regarding substance use within the family.

NCSACW, 2004

In Home Assessment

An in-home assessment includes observations by the CPS caseworker. Here are some things to consider...

- Details of report
- Environment and conditions of the home
- Drug Paraphernalia
- Smell of drugs, alcohol or chemicals
- Physical signs of addiction
- Signs of withdrawal or current intoxication
- Other people in the home
- Admission to substance use

145

Other Factors to Consider...

- CPS caseworkers should also rely on additional techniques to determine SUDs in family members:
  - Condition of the children
  - Observations
  - Medical histories
  - and the children
  - Arrest records
  - Reports from family members, neighbors, friends Collateral contacts familiar with family members.

146

Remember....

Substance use or the presence of a substance use disorder DOES NOT automatically indicate parental impairment or present an issue with child safety;

IT IS ONLY ONE FACTOR IN THE OVERALL ASSESSMENT OF THE FAMILY

147

Critical Decision Point

Decision Making and Prevention Planning

What Decision Would You Make?

- Prevention Plan-In Home Case
- Prevention Plan and place children with relatives
- ECO and OOHC

149

The Jones Family Scenario

- What decision would you make and why?
- What factors would need to exist to work this as an in home case?
- What would a prevention plan include if children are placed with the grandparents or other relatives?

150

Does Drug Addiction Equal TPR?

- No!! Drug dependency does not automatically mean the case will end in TPR.
- Too early to make a permanency decision.
- All is not lost!!!
- Good case planning needed.
- Make sure treatment and DCBS goals are aligned.
- Continue to engage parent.
- Goal of reunification.

151

Shared Decision Making

- Regular FTMs to plan and make team decisions
- Includes parents, DCBS worker, community partners, family supports
- Family driven , strength based approach
- All have part in decision-making process
- No secrets and no surprises
- Each system knows their "role" but contributes info
- Helps with family engagement and "buy in" with plan

152

Case Planning:

Substance Abuse Treatment Services and Responding to Relapse

Three Different Plans?

START Family Mentors who have been in our system tell us the following:

- They wanted help but didn't how to go about getting it.
- DCBS case plan , treatment plan and court orders may be different and this is confusing.
- Set up for failure when providers and systems are not on the same page.
- More likely to follow the plan if they helped develop it and agree to it in advance.
- If the worker, counselor or Judge was "in their corner" this helped them to keep going.

154

The Jones Family Scenario

- What kinds of activities would go in this family's case plan? For Parents? Children? Grandparents? SSW?
- How can you help family engage in services such as a substance use disorder assessment or recovery support group?
- Response to relapse?
- Relapse prevention planning-what would this look like from a child welfare perspective?

155

Recovery Supports:

- **Sober support system is key to recovery!**
- **Helpful in conjunction with the treatment process**
- **Have community recovery support listings available for families.**
- **Community based and faith based meetings:**
  - 12 step meetings- AA, NA, Al-Anon
  - Celebrate Recovery
  - SAVE
  - Lifeline
  - Church
  - Treatment alumni groups

12 STEP MEETINGS

LIFE LINE CONNECTION

CELEBRATE RECOVERY

156

Tips for Assessments

- Communication is critical in this process!!!!
- Make call with your client to schedule appointment.
- Prepare your client for what to expect at assessment.
- Warm hand off can make a difference in engagement, follow through and assessment results.
- Go to appointment with client if possible.
- Talk to provider who will be conducting the assessment- do this before the assessment occurs.
- Follow up with provider and with client about how the appointment went.

157

SUD Assessment or Evaluation

- Assessment results are directly related to the quality of information provided to the counselor conducting the evaluation. Following info should be provided:
  - ✓ History of arrests and convictions.
  - ✓ Condition of the home when home visits were conducted.
  - ✓ A history of SUD related information (has the family member been in treatment before?)
  - ✓ Case history and collateral information.
  - ✓ Child safety concerns.
  - ✓ Other concerns learned during the investigation (i.e. child maltreatment due to suspected substance use)

158

Federal Regulation 42 CFR Part 2

- Protects confidentiality of a patient/client's alcohol and drug abuse treatment records.
- Added layer of protection and confidentiality.
- Purpose to encourage treatment participation.
- Must sign appropriate release/sharing of information in order to access this information.
- DCBS and treatment provider will each have own release of information.
- No redisclosure of information or records without the appropriate releases.

159

Update on the Jones Family Situation

Two Steps Forward, Three Steps Back??

160

Understanding Relapse

- It happens. We should not be surprised or angry.
- We should always be planning for relapse.
- Relapse is a process not an event.
- Involves the person reverting to old attitudes, beliefs, values and at risk behaviors.

161

Understanding Relapse

- Relapse is NOT a of recovery-it is part of addiction and sometimes happens during the process of recovery.
- Different levels of relapse:
  - Slip; Binge; Return to active addiction
- Client can learn and grow from a relapse.

162

Relapse Happens.....

- Addiction is a relapsing condition.
- All is not lost.
- You have not done something wrong.
- Could "lose" the parent at this point.
- Time is of the essence!!
- Not a time to be punitive.
- Window of opportunity to re-engage your client.

163

Responding to relapse...

- Parent is in crisis- we don't overwhelm them or set them up to fail.
- Support and specific, clear direction.
- Keep it simple.
- Parent involvement in own plan to move forward.
- Individualized plan:
  - Keep appointments with SA Tx provider
  - Work on relapse prevention plan development with treatment provider and worker
  - Keep visitation with children

164

Relapse Prevention Planning

- Different perspectives:
  - ❖Child Protection
  - ❖Substance Abuse Treatment
- Plans must be made early and continually discussed and/or updated.
- Ideas:
  - If sobriety is threatened, where will parents and children go?
  - Who will parent call? Have #'s available of sponsor, counselor, family.
  - Discuss plans in advance with "safe" supports.
  - Transportation options in case of an emergency.

165

Planning for Reunification

Aftercare Planning and Strategies for Successful Reunifications

The Jones Family Scenario

- What factors need to exist for reunification to be occur?
- How do we prepare the family for reunification?
- How do we help the family with the transition of reunification?
- How should we support and monitor the family after reunification?

167

Preparing for Reunification

- Sober parenting issues-some have never parented sober and can be ambivalent about this.
- Plan in advance for relapse.
- Address family Issues (co-dependency, Al Anon)
- Services for children should be in place.
- Working on increasing parental capacity to care for the children (not just compliance).
- Life skills (GED, Employment, Budgeting, Housing)
- Recovery Supports for parents!!!!
- Visitation increases to unsupervised and overnights.

168

Reunification: A Stressful Time for Families

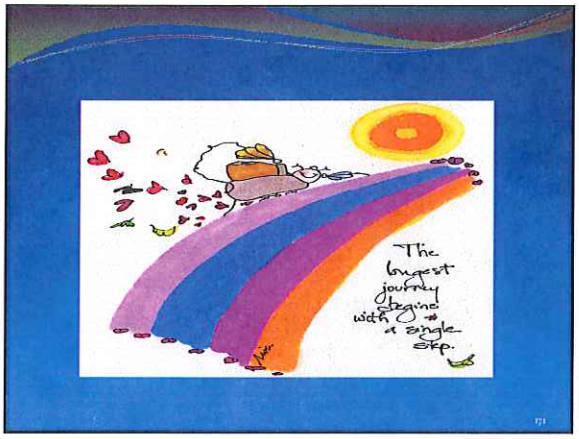
- Dosage of OOHC and why this matters…
- Acknowledge to the family that this is a stressful time for them and you are there to help!
- Involve service providers to understand what parents and children will need during this process.
- Considered a longer term staggered reunification.
- FTM at least 30 days in advance of reunification with all team members and family to develop a solid transition plan.

169

Reunification and In Home Services

- Make sure you have developed a relapse prevention plan with the family.
- Consider protective factors and involve friends and family to assist with the transition.
- Consider FRP to help with reunification transition.
- More intensive home visits upon reunification.
- Another FTM after reunification to see how things are going and what needs are present.
- Monitor at least 3-6 months after reunification.
- Watch for self sabotage on the part of parents.

170



171

Name Three Things…..

- What can you take from today's training to help you in your day to day practice???

172

NCSACW On Line Training

- http://www.ncsacw.samhsa.gov/tutorials/RegForm.aspx
- Tutorial 1: Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals
- Participant Workbook (PDF)
  Designed to be a companion to the course. It features reading questions, and self-reflection and goal-setting exercises to supplement each module.
- Facilitator Workbook (PDF)
  Designed to help substance abuse treatment professionals use this tutorial to train multiple staff members on the child welfare and dependency court systems.

173

NCSACW On Line Training

- Tutorial 2: Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals
- Participant Workbook (PDF)
  Contains Reading Questions based on the online tutorial to help caseworkers identify key concepts and support their knowledge acquisition.
- Supervisor Workbook (PDF)
  Allows supervisors to become familiar with the training materials and plan for training completion, follow up, and mentoring.
- Tutorial 3: Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Legal Professionals

174

REFERENCES

- Child Abuse and Neglect User Manual Series "Protecting Children in Families Affected by Substance Use Disorders"
- Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR) Manual, SAMHSA 2007
- Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers, US Dept Of Health and Human Services, SAMHSA, 2009
- Engaging Families in Child Welfare: A Brief Review of the Literature; Research to Practice Initiative, Child Welfare League of America
- Engaging Child Welfare Families: A Solution-Based Approach to Child Welfare Practice, Christensen, Dana N, PhD & Antle, Becky, PhD, Center for Family Resource Development

176